IMedReviews
14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

DATE OF REVIEW: 11/19/2015

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Epidural Steroid Injection # 1 L4-5 using Fluoroscopy.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

D.O. Board Certified in Anesthesiology and Pain Management.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]

Patient is a female who was injured on xx/xx/xx. She started having back pain and was diagnosed initially with lumbar spine sprain. Treatment included 12 sessions of physical therapy, muscle relaxants, and nonsteroidal anti-inflammatory drugs.
An MRI done on showed degenerative changes at L4-L5 with annular tear and right L4-L5 facet hypertrophy with small synovial cyst and edema extending from pedicle sets into the paravertebral soft tissue. Patient's physical exam on revealed low back and hip pain, pain located at L5-S1 level with radiation to sacroiliac area. Pain is aching in nature increases with movement, limited ROM in lumbar region, no tenderness on palpation, and no paraspinous muscle spasm. Deep tendon reflexes were graded as 1-2 plus and equal throughout. Negative straight leg raise test, negative Patrick's and Babinski's. The sensation is intact to light touch, pin scratch, motor intact throughout.

On patient was seen again after MRI and had no subjective complaints recorded, no objective or physical findings were documented.

ANALYSIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION AND EXPLANATION OF THE DECISION. INCLUDE CLINICAL BASIS,

Per ODG references the requested" Lumbar Epidural Steroid Injection #1 L4-5 using Fluoroscopy." is not medically necessary.
No radicular symptoms were noted on physical exam, negative leg raise test, the MRI showed no evidence of nerve root impingement which does not support evidence of radiculopathy, no EMG was performed to support any radicular pain, no documentation of home exercise program and the conservative treatment has not been maximized in this case, therefore the ESI under fluoroscopy does not meet the clinical guidelines.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES